NEW JERSEY
MEDICARE SUPPLEMENT UNDER 50 COVERAGE PLAN BOARD

NOTICE OF ANNUAL MARKET SHARE FILING REQUIREMENTS

The New Jersey Legislature enacted P.L. 1995, c.229 (C.17B:26A-12 et seq.) to make Medicare supplement coverage available in New Jersey to residents under age 65 years of age who are eligible for Medicare. Certain provisions in this law authorized a mechanism for providing Medicare supplement coverage to the under age 50 market by creating a plan which by regulation N.J.A.C. 11:4-23A.3 became known as the Medicare Supplement – Under 50 Plan. The Under 50 Plan is administered by the Under 50 Plan Board. In carrying out its mission of providing Medicare supplement coverage to individuals under age 50 who become eligible for Medicare benefits due to disability or because of end stage renal disease, the Under 50 Plan is authorized to assess carriers (including insurers, health service corporations, and health maintenance organizations) issuing health benefits plans for their proportionate share of organizational, operating and net losses of the Plan unless the carrier has received an exemption or deferment from the Commissioner of Banking and Insurance (N.J.S.A. 17B-26A-15, N.J.A.C. 11:4-23A.9 et seq.). The assessment of each carrier is in the proportion that its net earned premium bears to the net earned premium of all carriers (except that no carrier shall be liable for an assessment amount greater than 35% of the total net losses of the Under 50 Plan in any calendar year). In order to calculate the assessment shares, each carrier is required to file the attached market share report on or before March 1 of each calendar year.

For assessment purposes under N.J.A.C. 11:4-23A et seq., "health benefits plans" means a hospital and medical expense insurance policy, hospital service corporation contract, medical service corporation contract or health service corporation contract delivered or issued for delivery in New Jersey or a health maintenance organization subscriber contract delivered or issued for delivery in New Jersey. "Net Earned Premium" means the direct premium earned in New Jersey on health benefit plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plans. The second page of these instructions identifies in detail those premiums to be included in or excluded from the definition of health benefits plans premiums.

If you do not report accident and health premium on your annual statement for the New Jersey Department of Banking and Insurance, you must file all three pages of the Market Share Report certifying that you have no premium to report. If you do report accident and health premiums, you are presumed to be subject to assessment for the entire amount reported unless you file a completed Market Share Report which shows what portion of the reported premium is subject to assessment.

Donald Bryan
Acting Commissioner of Banking and Insurance

MARKET SHARE CALCULATION

"HEALTH BENEFIT PLAN" DEFINITIONS

For this program, the market share of each carrier/HMO is to be in the proportion that its net earned premium on health benefit plans bears to the net earned premium on health benefit plans of all carriers/HMOs. The following definitions are from NJSA 17b:26a-12 and NJAC 11:4-23a. Net earned premium should be calculated as direct premium prior to the impact of reinsurance ceded or assumed.

"Health Benefits Plan" means a hospital and medical expense insurance policy, hospital service corporation contract, medical service corporation contract or health service corporation contract delivered or issued for delivery in New Jersey or a health maintenance organization subscriber contract delivered or issued for delivery in New Jersey.

"Net Earned Premium" means the direct premium earned in New Jersey on health benefit plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plans. "Net Earned Premium" shall include the aggregate premiums earned in the insurer's insured group and individual business and HMO business, including premiums from contracts covering Medicaid and Family Care recipients and the insured-paid portion of Medicare Advantage contracts. "Net Earned Premium" shall not include premiums from stop loss or excess coverage to the extent that such coverage:

1. Is issued to self-funded arrangements to reimburse only the self-funded arrangements for expenses exceeding per person or aggregate limits, and for which employees or other individuals are not third party beneficiaries under the policy; and
2. The per person limit is no less than $20,000 per year, and additionally, or in the alternative, the aggregate limit is no less than 125 percent of expected claim

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The Under 50 Coverage Plan Board has adopted the following guidelines to be used in calculating carrier market share.

Coverages Included: Group, Individual, HMO Contracts of

Major Medical Coverages
Medicare Supplement
Medicare Advantage (premium from insureds only)
Medicaid and FamilyCare
Accident Medical
Student Accident & Health Medical (expense incurred)
CHAMPUS
Specified Disease (expense incurred)
Limited Benefits (expense incurred)

Coverages Excluded:

Disability Income
Long Term Care
Vision (separate contract only)
Dental (separate contract only)
Accidental Death & Dismemberment
Medicare Advantage (premium from Federal Government)
FEHBP (contracts funded by the Federal Employee Health Benefits Act)
Stop Loss (as defined in Net Earned Premium above)
Self-Funded Arrangements
Credit Disability
Hospital Indemnity
Prescription Drug (separate contract only)
Short Term Travel
Specified Disease (Indemnity)
Accident (Indemnity)
Limited Benefits (Indemnity)